DOCUMENT RESUME

ED 170 419 UD 019 376

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TITLE Trying to Make it Real: Issues and Concerns in the Provision of Services for Minorities.
INSTITUTION New York City Dept. of Mental Health and Mental Retardation Services, N.Y.
PUB DATE May 78
NOTE 51p.; Not available in hard copy due to reproduction quality of the original document ; Paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues (Denver, Colorado, May 22-24, 1978)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Community Involvement; *Cultural Factors; Financial Support; *Health Needs; Health Services; *Human Services; *Mental Health; *Minority Groups; Psychiatric Services; Psychological Services; Service Occupations; Social Action

ABSTRACT

After asserting that minorities do not have the health resources available to them in quantity or quality as do members of the dominant society, this paper describes and discusses six features which should characterize appropriate mental hygiene services for minorities: (1) cultural relevance; (2) a holistic orientation; (3) an organizational structure that supports coordination; (4) priority attention to certain target groups; (5) the use of community support systems; and (6) minority involvement in decision-making, accountability, and quality assurance. Recommendations for improving the effectiveness and availability of human services for minorities and for increasing minority participation in service systems are made for each of the areas discussed. Recommendations are also made for the establishment of a sound financial base by Federal, State and local governments in order to make significant reform possible. (Author/EB)

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APR 2 7 1979

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TRYING TO MAKE IT REAL:

ISSUES AND CONCERNS

IN THE PROVISION OF SERVICES FOR MINORITIES*

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UD019376

*Prepared for Presentation at the Denver, Colorado, National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues, May 22-24, 1978, sponsored by the Alcohol, Drug Abuse and Mental Health Administration of the Department of Health, Education and Welfare and the ADAMHA Minority Advisory Committee.

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To acknowledge the complex interrelationships among the social environment, interpersonal relationships, and the inner emotions of individuals who happen to be members of racial and ethnic minorities, it is necessary to be aware of certain factors which are significant in their lives. They include the historical determinants of present day minority life, the social reality of that life, and the psychological effects of poverty, segregation, discrimination and deprivation, conditions imposed by the majority upon the minority. Awareness of these factors helps to direct attention to the totality of the life situation of minorities.

This paper will not attempt to deal in depth with the varieties of individual and group experiences both among and within minority groups. Their past histories are too varied; their current lives have their own group specificity. The historical determinants of the lives of minorities in this country still influence them today: the near-annihilation of Native Americans and their restriction to lives on reservations; the legal exclusionary immigration practices against Asians and the all too recent herding of Japanese Americans into concentration camps; the past and present colonial mentality directed toward Hispanic Americans; and the inhumanity of 300 years of slavery and its vestiges in lynching, Jim Crow and de facto segregation imposed upon Afro-Americans -- all of these are not only part of history, but leave their remnants in current life.

The characteristics of that present-day life differ, not only from group to group, but within each of these peoples. The varieties of Indian tribal life and the differences among Native Americans' lives in city, country or on reservation; the dissimilar backgrounds of Hispanic Americans, depending

upon their place of origin in Mexico, Puerto Rico, other parts of the Caribbean or South America; the cultural and racial differences among Spanish-speaking people, depending upon the degree to which their roots are African, Indian and/or European; the great social and economic differences among Afro-Americans and the cultural differences among Blacks of Latin, West Indian, or continental United States background; and the differences in national origin among Asians from Japan, China, India and, more recently, the Pacific Islands; the differences in philosophy among those Asians who are old immigrants and the new -- all these contribute their own diversity.

And yet, there are commonalities which are present, with certain notable exceptions, among most members of these minority groups. As colored peoples, they have experienced the racism, discrimination and prejudice of past and present life in the United States. The attitudes and behaviors which characterize racism have in recent years no longer been accepted with suppressed anger, but have been turned against the aggressor, most constructively, in civil rights activism. With consciousness awakening in these groups, they have seen their pride as minorities become a tool for change and have pointed to their past traditions, their "roots," and their cultures as evidence of their strength of survival and as the opportunity to enhance the richness of American life.

On the other hand, they share the common experience of being more or less relatively powerless, politically weak, and over-represented among the poor, the under-educated, and those in poor health. For some, alcoholism, drug abuse and psychiatric illness for which the State hospital is the only service available are the expected. With few exceptions, they do not have

the health resources available to them in quantity or quality as do members of the dominant society. With few exceptions, they have not had access to the higher education that would produce the health and mental hygiene professionals; those professionals who do exist, in the exceptional instances, for example, among the Asian health professionals, generally do not serve their own communities.

The health services which minorities have to turn to are fragmented, uncoordinated and often inappropriate to their needs. Barriers to utilization exist; the control is generally in the hands of the white majority for whom those services are developed.

Thus, to describe those characteristics of comprehensive service appropriate to meet the needs of minorities, this paper will discuss certain features which are considered applicable to most members of these minorities rather than focusing on the individual variations of service best suited for each group or summarizing a literature lacking in comparative studies.

For many years, minorities were the forgotten men and women of mental health literature. Even today, it is difficult to find articles that deal in any depth with the question raised. It is not only that the literature does not refer to minorities to any great extent; but it is also that articles tend to be descriptive rather than analytic, to err no longer by comparing minorities with majority in an inferior-superior mold but, on the other hand, not to report efforts to evaluate the efficacy or effectiveness of comparative approaches to service.

Six features should characterize appropriate mental hygiene services

for minorities: cultural relevance; a holistic orientation; an organizational structure that supports coordination; priority attention to certain target groups; the use of community support systems; and minority involvement in decision-making, accountability and quality assurance.

Recommendations will follow the presentation of each; the overreaching concern for a sound financial base is the closing issue.

CULTURAL RELEVANCE

Ethnic differences have generally either been overlooked, denied, or used to justify discriminatory acts on the part of the dominant majority (Christmas, 1977a).

Since racial pluralism and ethnic diversity are persistent and real factors of American life, mental health and other human services should not only acknowledge ethnic characteristics, but become sensitive and relevant to ethnic, racial and cultural factors in a positive way that builds appropriately upon this diversity. This implies bi-culturism, sensitivity to the cultural dimensions of groups, their life styles, language and interactional patterns (Bullough, 1972; Knoll, 1971; Martinez, 1973).

The need for cultural relevance and the development of services which take into account ethnicity and culture are of particular significance. Specific social and cultural mores, ethnic group values, and varied familial patterns are among the aspects of culture-specific services which ought to be addressed in program design and operation.

This means that programs must not only be <u>in</u> but <u>of</u> a particular cultural group. They must take into account the value that the particular group holds; the way the group defines health and illness; who its caretakers are; who it turns to in time of trouble. They must consider, for example, that behaviors such as heavy drinking may be culturally-syntonic but the complications that result from these socially accepted acts, while destructive, may not necessarily be recognized as related to the value system which the group holds. This is cited particularly in regard to the heavy drinking

among Blacks and Indians and the difficulties in the Black community, for example, of acknowledging heavy drinking as a symptom of alcohol dependency rather than solely as a social custom.

But when social factors are taken into consideration, this should not occur in a way which tends to devalue them per se. On the other hand, the relationship must be made between the reliance upon alcohol in its utilitarian role or the reliance primarily on corporal punishment of children as a means of discipline, or the shame of admitting mental illness and the possibility of problems. Each of these culturally acceptable behaviors may lead to difficulty. There should be examination, for example, of the changing role of women in current Mexican American family life, without applying the standards of the Women's Liberation Movement (Gibson, 1978).

It is suggested that culture-specific models of service delivery be developed which integrate the positive, constructive values of traditional helpers into more conventional treatment modalities, with appropriate modifications to meet the need of minorities. Drawing upon the folk healers, the traditional medicine man or woman of Indian peoples, the curanderos of Hispanic communities, the healers of Black neighborhoods, in a way that allows them and Western approaches to health and mental health services to be complementary to each other may increase utilization of services by the particular socio-economic group of minorities who customarily turn to these helpers (Belcourt, 1977).

The subject of culture and the need for biculturalism become particularly important when related to the need for bilingualism. It is

not enough to have intake staff who are able to be bilingual and interpret the works of the new immigrant in her particular language or dialect. It is essential to have services, particularly in the "talking therapies" that are conducted in the language in which the clients are versed, comfortable, able to express feelings, ideas, and wishes. Particularly in regard to the counseling services for emotional problems, communication is the essential vehicle (Sue, and McKinney, 1974).

Beyond this is the use of actional, group counseling, and group therapy approaches conducted in the language and style of the minority group. These may be more feasible when coupled with the creative use of minority professional and paraprofessional staff. The use of group approaches with multiple interdisciplinary team leaders, composed of some persons who do understand the culture of the clients,not only assists them to participate more actively, but may also be a vehicle for broadening the cultural awareness of the other team professionals. (In short, the shortage of minority professionals should not doom minorities to continue to wait, without services, until these inequities can be redressed, nor should it be assumed that non-minority staff can play no role in the provision of services to minorities. Yet, the importance of knowledgeable minority staff in service and in leadership positions can enhance the possibility of cultural relevance of programs, provide role models, and increase the understanding of majority personnel).

When there are large numbers of minorities, as often happens in areas where there are Black and Hispanic persons, it is possible to design services

that are characterized by the cultural practices of the particular minority and to provide those services within the ethnic community, on a geographic base for a defined population. But this is not so likely in those situations where smaller numbers of minorities live, on the edge of or in the midst of communities where services are developed for a predominantly white majority (Ho, 1976; Huang, 1977; Kitano, 1973). In those instances, culturally relevant services may have to be developed on a regional basis, with services shared by several catchment areas, for Native Americans, for example.

There is another element to cultural relevance based on the fact that minority groups live within a wider majority society which significantly influences their lives. The force with the greatest impact upon minorities is the existence of racism, its negative effect upon growth and development, and its restriction upon the ability of individuals and groups to function fully and constructively in society.

From consideration of the social and economic factors that racism, discrimination and prejudice impose upon minorities and from consideration of their responses to such oppression, come efforts to develop program settings, which include in the realm of mental health, ways of coping constructively with these stresses. Thus, additional recognition is given to the need to incorporate appropriately, social action to deal with oppression, with socio-economic discrimination, and with the triple jeopardy imposed when one is mentally disabled and economically deprived, as well as a member of a minority in a racist society.

RECOMMENDATIONS

1. The rights of minority patients in health, mental health, alcoholism and drug abuse programs should be duly recognized, particularly as they relate to their unique cultural, linguistic, and ethnic characteristics, and to their historical and life experiences.

2. Mental health policies should contain specific provisions which acknowledge the unique cultures, languages, and lifestyles (including immigration experience) of minorities, and reflect the cultural, racial and ethnic differences among minorities.

3. Culture-specific and relevant models of service delivery should be developed and implemented which integrate the traditional or folk medicine, the values, and the support systems of minorities with conventional treatment and rehabilitation modalities.

4. Agencies must hire minority bilingual/bicultural staff at the service, support, administrative, management,planning and supervisory levels.

5. Indigenous paraprofessionals from minority communities should be accepted for training, employment and upgrading in the mental hygiene field with career ladders and career lattices for upward and lateral mobility. Recognition should be given to traditional healers, the traditional medicine men and women and other folk healers as helpers of those with emotional, mental and physical disorders.

6. Mechanisms for reimbursement for health and mental health services (e.g., national health insurance, Medicare, Medicaid, etc.) must include culturally traditional forms of assistance.

7. Research funds should be allocated for the purpose of demonstrating the effectiveness of traditional medicine as a part of comprehensive programs of treatment and prevention.

8. The Federal Government should give direction to training programs so that they develop curricula that will produce professionals who recognize, understand and utilize the dynamics of individual and institutional racism and who are sensitive to and knowledgeable about the varieties of culture and ethnicity.

9. Local, State and Federal agencies should develop and implement mental health training programs that provide learning environments and curricula congruent with the various cultures and the mental health needs of minority Americans.

10. Training funds specifically designated for the development of minority mental hygiene paraprofessional and professionals to serve minority communities (and other communities) must be increased.

11. Mental health training programs must be established, both under minority and majority institutional auspices, that will provide teaching of cultural differences and the psychology of minority men and women from a positive frame of reference.

12. Educational programs for non-minority mental hygiene service providers must be required in all areas that serve minority American clientele in order to increase knowledge and sensitivity to those clients.

13. Accreditation agencies for service and training should be mandated to include in their evaluation reviews the quality and quantity of recognition of and responsiveness to cultural factors in regard to minority populations.

THE HOLISTIC APPROACH TO SERVICE

The holistic orientation is the second dominant theme. In this view, the individual is seen not as an isolated entity separated from society or living within a vacuum but as a human being related to other individuals, interacting with family and society; the whole person must be the subject of consideration; programs must address the human totality.

From this view, a psycho-social approach is developed which takes into account psychological, social and behavioral referrents. The interrelationships of these referrents are particularly significant for persons who occupy positions of low or marginal social status, who experience continuing deprivation, or who occupy a devalued imposed social position, as do members of racial or ethnic minorities. This view holds that the usual therapeutic interventions, directed separately, if at all, to individual psychiatric or social conditions or to individual conditions of health or disease, without multiple coordinated and sustained efforts,are of reduced effectiveness (Christmas, 1972).

Persons who suffer the disadvantages of poverty, discrimination and mental illness need to cope, not only with the symptoms and effects of mental disorders, but with environmental stresses as well. Appropriate and effective services give recognition to the significant transactions between the individual and the environment. They are directed, not only to individual pathology, but toward individual and group strength, not only toward easing inner tensions, but toward coping with environmental stresses, stresses that may themselves have been among the determinants of illness.

In this conception, goals reach beyond those of restoring a previous state of equilibrium, of handling symptomatology, or of dealing solely with reality problems. They encompass helping an individual to achieve his or

her own potential, to improve social functioning, and to relate more effectively to the familial and social environment. This approach seeks to develop innovative measures that not only strengthen integrative intrapsychic and interpersonal forces, but also circumvent and alter external forces which impinge upon the lives of individuals and groups. It seeks, further, to encourage the development of competence and power by persons who have been excluded by virtue of factors such as psychiatric label, race, social or economic position (Cameron and Talavera, 1976).

Emphasis is placed on prevention, on mobilizing the potential for health, strength, and drives toward growth, autonomy and self-actualization. It is based on the fact that human beings grow, change and develop under manifold circumstances not limited to those traditionally considered as help. The ability of most people to survive the stresses of life as a minority in a racist society is striking. Psycho-social approaches, addressed to the strengths and resources of persons living with both success and failure, under conditions of chronic poverty, discrimination and societal rejection, may result in their functioning more effectively and in greater effectiveness if these services are utilized as change efforts. In addition, the knowledge acquired from observation of individuals and groups striving toward social articulation within a society which has rejected them because of their race, social class, physical handicap or psychiatric diagnosis, can contribute to an understanding of the developmental tasks occurring at critical stages of life and of the transactional relationships between human beings and the environment.

Recognition is given to the existence of racism, economic inequities, prejudices and discrimination in the lives of most minorities. Institutionalized racism is one of the social factors that must be taken into account

in the content of services. Thus, the line is not always clearly drawn between socio-therapeutic interventions and social action. Services directed toward changing and improving the individual and familial situation are related to those directed toward social change (Lightfoot, 1970).

The holistic orientation implies that the inter-connections between the psychological, social, economic and interpersonal aspects of the life of an individual or a family must be dealt with in ways that are appropriate to that particular individual. Acknowledgement is given to psychodynamics in regard to intrapersonal conflicts but, at the same time, greater attention is paid to interpersonal and societal factors. A coordinated, total service approach, with a multi-focused range of services is inter-disciplinary in staffing (when part of a formal program) or addresses multiple needs through linkages among varied programs. Continuity of service and care are critical in providing comprehensiveness.

The concept of empowerment of individuals and groups serves to provide the link between this orientation and the creative use of community institutions as social supports. Whereas social science has generally considered minorities from the vantage point of superiority-inferiority, and has developed concepts based on model of deficiency, this orientation, on the other hand, looks for the strengths within the individual, the family, and, significantly, in the cultural and ethnic group. Recognition of strengths addresses the fact that minorities have within their social structure and within their history evidence of ability to not only survive societal pressures and oppression, but to develop coping mechanisms which might well be adapted to other groups in both social and therapeutic situations (McAdoo, 1977).

Further, from the holistic viewpoint emerges the idea that persons who have themselves functioned with some degree of success in some of the social systems under consideration, may be enabled to engage in helping transactions with those more damaged or less successful in their functioning, with success defined in terms of either the narrow or wider systems (Taber, 1970). Experience has led to the conclusion that trained paraprofessional mental health personnel, recruited from the local minority community, can provide an added dimension to services delivered by professionals.

The development of such new roles for professionals and paraprofessionals, and the related modifications in services, may lead to improvement in the nature and the quality of services. Moreover, the use of a previously untapped human resource may contribute to a solution of the manpower shortage. Beyond these factors, however, there exists another basis for the human service worker drawn from the ranks of the minority disadvantaged -- the use of the product of a social problem to cope with, alter and resolve the problem. As those labeled as patients are able to cope more successfully with their environment, as well as those who have managed to avoid the status of patients, they may themselves alter this environment. The salient feature of New Careers in mental health, is that members of minority groups, whose potential for productive roles for themselves and for productive services to others has not been fulfilled, are enabled, through special educational experiences, to contribute not only to the development of others, but to the realization of their own resources (Christmas, 1969).

RECOMMENDATIONS

1. Preventive services in mental health programs must be an integral component of a range of mental health planning, services, and research; along with

treatment, habilitation and rehabilitation, prevention should be funded to provide a range of services.

2. Federal, state and local mental health programs should be flexible to allow and encourage the implementation of innovative models of service delivery appropriate to the needs of minorities in different settings.
3. Research funds should be made available to encourage and support innovative service delivery approaches and their evaluation.
4. Human services should be delivered to minorities in the context of available and accessible multiservice centers providing acceptable health, mental health, social welfare, educational, economic, and legal services based upon the concept of the minority family in its community.
5. Family Resource Centers should be developed, to include systematic comprehensive family support services as part of the national urban policy. State and local health and welfare policies should support such centers.
6. Minority staff should be employed in sufficient numbers and so assigned as to maximize their visibility and influence upon the nature of the service delivery system.
7. In areas where there are large numbers of minority individuals, programs should be designed to provide specialized services to those minorities needing both bilingual/bicultural services, with appropriate staff.
8. Priority should be given to funding for the development of innovative, social and residential programs in minority communities as alternatives to traditional medical institutions providing mental health services.
9. Funding and policy should encourage the development and evaluation of alternative mental health service delivery models for community social institutions, self-help groups, neighborhood service programs, and

"school-as-community" programs.

10. There should be established a clearinghouse for information on promising model programs so that minority communities can have access to and benefit from the experience of other similar communities.

11. A Technical Assistance Branch charged with consultation to community groups which wish to start mental hygiene programs should be established and staffed by knowledgeable professional staff.

ORGANIZATION FOR COORDINATION AND LINKAGES

From the holistic orientation emerges the view that creative use should be made of community-based programs and of the transactional relationships between individuals, families and community to enhance, support, and assist the process of growth, recovery or rehabilitation. In this view, the stresses of the social environment can be used planfully to aid individuals and groups to develop techniques of mastery, strengthen effective coping mechanisms and acquire social learning, and to alter one or more of the social systems in which they are participant. Thus, the harsh realities of economic and social stress are not viewed simply as interferences to be eliminated so that orthodox treatment or rehabilitation can take place. They are, rather, significant aspects of the lives of people, aspects to be understood and dealt with as forces for growth or as disturbance. Indeed, the helping process is considered as necessarily including involvement in learning to deal with the environment, in altering the damaging aspects of reality, in reinforcing the strengths of individual groups, and in enhancing social networks.

This implies, then, the need for coordination with other health and human service organizations and the development of services that are accessible and available to individuals.

Access is defined not only as physical access but as the creation of an atmosphere which makes a program inviting to an individual or ethnic group, and in fact, reaches out to bring that person in. It is here that cultural relevance becomes important when certain subtle or overt signs are given to minority groups that they are not wanted, either

by the location of the program, the hours a particular service is offered, the physical structure, or the lack of any minority persons in any positions of power and/or visibility .

Availability includes the concept that services are not only offered but that they are economically and finacially within the reach of the individual.

The concept of comprehensiveness for minorities includes not only the provision of services that deal with the social, economic and cultural factors referred to heretofore, but the importance of effective linkages with other human services.

This integration can take many forms. Contracting to minority community-based organizations for the delivery of such services wherever they exist is one model. Another is the integration of existing services, such as mental health, with other community services which have more widespread acceptance, such as youth programs, family and child care services, senior citizen centers, and social clubs.

There are two relevant approaches, each with its advocates. One view is that mental health and alcoholism services should be offered in specialized kinds of settings (CMHC's, alcoholism treatment centers) with linkages to other human services such as education, employment, and social services. This is based on the need for a high degree of internal specialization. The other view is that the stigma of receiving services for mental disabilities is so great that it may be better to provide these services within the general health care system (Gullattee, 1972) or, alternately, within the general human service system, as in social welfare agencies, or within the edicational system. There is no evidence to

suggest that either approach may have the advantage over the other.

However, in those communities where numerous community organizations, civic associations, ethnic groups, lodges and clubs, abound (as in the Afro-American communities) few linkages exist to service programs for persons with mental disabilities and substance abuse problems. Nevertheless, there is a base to build upon within these communities where coordination and linkages could exist and where easier access to services could come about, if action were taken to arouse the interest and responsibility of community organizations and leadership, latent and overt.

It is apparent that the human service agencies are not themselves, coordinated, and the services that people have to deal with are frequently provided under a multiplicity of auspices by agencies whose staff rarely talk to one other. It is not only that fragmentation exists in the service system but that the individual is forced to move from one agency to another to maneuver a service system without having a sense of the whole. In the prime of the New Careers Movement, paraprofessionals played the linking, expediting role quite effectively, long before the term "case manager" became chic. Indeed, the case manager role was well played by paraprofessionals from minority communities during the War on Poverty. Although used extensively in the rehabilitation services provided at the Harlem Rehabilitation Center (Christmas & Daniels, 1978), the community worker/expediter role seems to have vanished in many instances, the victim of fashion in mental health and lack of Federal funding.

An alternative approach for the integration of services can be seen in the development of interagency coordinating councils. But this requires the presence of several programs, some of which may not necessarily be

as acquainted with the needs of minority families as others might be. The danger here is that the agencies and their newly identified super-structure become another bureaucracy, rather than aiding an individual to manuever successfully through the system.

RECOMMENDATIONS

1. There should flexibility of organizational arrangements in the provision of services so that coordination, availability, and accessibility can be fostered in a service system that takes into account minority socio-cultural characteristics in staffing and programming.
2. Programs designed to provide human services to minority Americans should provide for closer liaison with mental health service delivery systems and personnel.
3. Liaison should be established between community organizations and mental health service-providing agencies.
4. Contracting to minority, community-based organizations for delivery of services, wherever such services exist, should be encouraged.
5. Integration of existing mental health services with other community services, such as youth services, family services, services to children, services to the aged, services for developmentally disabled, etc., should be one model developed and evaluated.
6. Mental health services should be made available, as an alternate model, within the context of primary health care programs, so that no illness is so radically different that "special" isolation is necessary, adding to stigma.
7. Aftercare and rehabilitation programs should be developed and implemented within the context of comprehensive human services that coordinate

community resources to provide social and cultural support throughout the rehabilitation period.

8. Administrative, program and fiscal arrangements must be made to allow minorities who are few in number in an area to be served across catchment boundaries when appropriate services do not exist in their catchment areas. In catchment areas with small populations, two or more catchment areas should pool resources, whenever feasible.

PRIORITY ATTENTION TO TARGET POPULATIONS

Although minorities as a whole are likely to be served poorly by human services or to be served inappropriately, some among them are at especially high risk. This includes children and youth, the elderly, and women, who, in a sexist racist society, bear a double burden. To draw attention to the need for addressing the specifics of their situation imposes an obligation to involve them in planning for its remedy.

Similarly, there are problems and disorders among certain minorities which warrant special attention (La Vietes, 1974; Harper, 1976; McNickle, 1968). The overrepresentation of minorities in State psychiatric hospitals reflects the failure to apply known rehabilitation techniques to minorities. Suicide and alcoholism among Indians; alcoholism among Mexican Americans; and alcoholism, homicide and suicide among young Black males are tragic indicators of the lack of successful intervention of mental health to alter self-destructive behavior (Faulkner, 1975; Paine, 1977; Resnik, 1971; Shore, 1972). The allocation of resources to drug abuse among minority youth probably reflects more of a concern over the outer-directed anti-social addict's behavior than for the drug addiction which is epidemic in some minority communities.

While overall Federal policy should be directed toward the population at large, these target groups, including especially the young, require the highest priority.

RECOMMENDATIONS

1. Priority attention should be given to the needs of minority children national policy, and through funding of service, training and research directed toward helping them cope with the damage caused by poverty, malnutrition and poor education, their legacy of deprivation and racism.
2. It is imperative for human service workers, along with minority youth, to plan, with governmental leadership, support and financial assistance, programs of prevention, treatment and rehabilitation for the mental health problems of minority adolescents, and for their integration into socially constructive work, school, and family roles in their communities.
3. There needs to be special attention paid to the unique role of minority women, their contribution to the improved mental health of minority people, and to the stressful and anxiety life situations they find themselves in by virtue of double discrimination. The particular sociocultural stresses faced by minority women should be studied, and the findings used to develop and implement counseling programs and other interventions designed to prevent emotional disorders and to build upon their coping skills.

4. Research monies should be granted to the development of alcoholism and drug abuse treatment centers for minorities which take into account the breadth of age, sex and cultural diversity within these groups and among them and which adapt their interventions to take advantage of these cultural factors.
5. The special needs of the elderly who are members of minorities warrant special attention through programs of the Federal, State and local governments. Minority elderly should participate in decision-making in this regard.
6. Mental health services to minorities who are overrepresented among the incarcerated in local, State and Federal institutions should be developed on a considered high priority need. The Justice Department and the Federal Bureau of Prisons must assume leadership in developing guidelines for health and mental health care in correctional institutions and for minimum standards of health and safety. Public and private rehabilitation programs for ex-prisoners should include mental health components among their services.
7. Federal policy should be given priority to rehabilitation of the chronically disabled. Although under the current CMHC Act a plan must be shown for deinstitutionalization, this requirement is not con-

sistently carried out. The Federal government should use the clout of funding to insure that specific plans for deinstitutionalization are developed and implemented. In fact, any funding for health for the geographic area, as well as for mental health, should be rationalized against this deinstitutionalization plan.

8. Such deinstitutionalization plans should clearly provide for retaining State hospital personnel with detailed means for dealing with seniority rights and for the establishment of career ladders and lattices to insure upward and lateral mobility upon retraining for New careers more appropriate to the delivery of community based services, to name a few key issues.
9. Currently known socio-psychiatric rehabilitation techniques should continue to be developed and utilized. Federal funds have gone into developing pilot programs to train service providers in these techniques. Such programs should be expanded through institutions established throughout the country based in programs such as Fountain House Institution, which focuses on vocational rehabilitation placements, and Harlem Rehabilitation Center which trains community paraprofessionals to help the lower socio-economic minorities who are the majority

of people remaining in State institutions.

10. The Federal government should take the leadership in developing funding and program development mechanisms which would encompass all the separate systems needed to sustain the chronically mentally disabled in the community. This would mean bringing together, with an emphasis on the priority for deinstitutionalization, such various Federal agencies as the Department of Labor, Housing and Urban Development, Rehabilitation Services Administration, and the various HEW component agencies related to social services, mental health, developmental disabilities and education for the handicapped. The Federal government should encourage multiple funding and models in which the multiple needs of the mentally disabled could be addressed through funds provided by various agencies.

The mechanism for doing this at a state level is the development of a single state plan which takes into account all the agencies involved. This must be initiated by a similar effort at interagency coordination and integration at the Federal level. Without this Federal leadership and the technical assistance to encourage the development at a local level by counterpart governmental agencies working with their provider system, local and state agencies may continue to ignore the opportunities to stretch funds. Thus, it is not enough to make the shift from a state operated mental health system

to local mental health services without this array of support services in the local communities. Localities need the encouragement to develop a single coordinated plan which such a Federal policy could give (Christmas, 1977 C).

COMMUNITY SUPPORT SYSTEMS

If mainstream services are judged, as they generally are, not to have been helpful to minorities, it may be in part because they did not address themselves to the needs in the settings in which minorities find themselves. To be effective services have to take into account cultural relevance, priority needs, and the use of the support systems that exist in minority communities. (Sotomayor, 1971; Sue, 1977).

A social support system has been defined as a means of continuing interaction among individuals and groups which provides ways that a person may know that he or she is cared for and loved, esteemed, and a member of a network of mutual obligations. These three critical functions which the community support systems may potentially fulfill relate to the basic social needs of individual relationships and attachments which provide trust, nurturance, and intimacy, i.e., emotional support; a sense of being valued by others, i.e., esteem support; and a sense of belonging to a community and of being a part of a group in which there are shared values, interests and obligations. In the past, some of these needs were met by the natural support system of the nuclear family and of the extended family. The pressures of urbanization, among other social factors, have contributed to a decreased ability to rely upon the extended family or even upon neighbors and friends for some of these supports. But, the necessity remains for social support to aid individuals in coping processes and in dealing with the normal stresses undergone in attempting to accomplish the transitional tasks of various life cycles (Christmas, 1977 d).

Thus, social support may have to come, to a greater degree than in the past, from community institutions to which people have traditionally turned for guidance, strength and comfort--organized religion, the health care system, and the natural community caretakers whose personal talents and empathy mark them as a source of solace or assistance.

Increased knowledge of the inter-relationships between social and environmental stresses and physical and mental illness has led to the creation of preventive approaches in order to enhance personality development and mental health. Here, community support systems have a vital role to play particularly as human services are called upon to move away from over-emphasis on and preoccupation with the "sickness model" and treatment to the much needed areas of prevention and rehabilitation.

This leads to the second area of innovation to which the concept of community support systems can contribute. The chronically mentally disabled have been among the expendables of society. They are fast being joined by others whom mental health and other human services have failed - children going through the harrowing experience of learning to be criminals in the juvenile justice system; the abused and abusing among adults and youth; the elderly discarded and neglected; and the alienated, the underemployed, and rejected racial minorities. Here, the functions of social support systems related to improving adaptive competence, helping people deal with critical life transitions and with long term challenges and stresses can be called into play in the service of rehabilitation. Community support systems can help to contribute to a sense of well-being and of competent functioning, and thus be preventive. They can aid in reducing the negative consequences of stressful life events and thus bridge treatment and rehabilitative levels to prevention. They can provide the ongoing source of skills in living and interpersonal relationships so needed by the chronically mentally

11 in the course of rehabilitation (Christmas, 1969). By building on constructive social institutions, they help to identify the strengths of minorities, the survival skills they have developed over time to cope, often more successfully than they may have been given credit for. This approach can foster the collection of information of potential applicability to helping professions (Thornton, 1975; Tuck, 1971).

Three theoretical principles underlying community mental health are relevant here. The first is that of the promotion of health as opposed to the remediation of disease. Here, these support systems can help develop coping skills, mastery and problem solving. The second principle is that services are directed toward populations and provided in localities to those at risk. The third is a commitment to use all resources within the localities rather than to focus only on professional clinical services. These are particularly appropriate.

The emphasis here is to help people where they are, whether at home, school, work or neighborhood or where they turn for help. This should assist in breaking down the barriers to help because it implies also drawing upon whatever culturally appropriate or existing institutions there are and seeing how they could contribute, as part of a neighborhood, to social support.

Another underlying principle is that of helping people to help themselves. This is based on the higher principle in which coping efforts are strengthened by helping-relationships in which mutuality of the support process give-and-take results in the helper being helped.

Helping people where they are and assisting them to help themselves allows entry into the help-giving and receiving system without requiring that a person be labelled patient or deemed "sick." This, too, may help to deal with the significant problem of stigmatization as a barrier to care. It may, equally, help to develop more appropriate and effective means of help.

There is a personal gain for people as they help themselves and decrease their sense of powerlessness and thus enhance their mutual help through a greater sense of competence and greater actuality of control. Building on natural strengths, not only with individuals but on networks within a community both formal and informal and on community institutions, will mean helping those institutions to discover their unused resources and helping them to make appropriate linkages with those who need these resources.

Even if it were to be desired, professional mental health services would be able to cope only with a small number of people who have immediate pressing psychological disorders. Thus, this approach can help find ways to both complement and supplement clinical services with programs that aim at reducing socially induced stress.

Among the approaches with great potential are those in self-help, with the creative use of untapped resources among minority men and women in their middle years, among youth and the elderly. But there is also the opportunity to revive the New Careers movement and to see how indigenous leadership can be used not only in strictly clinical mental health services but in new community services which minority neighborhoods so strongly need.(Gullattee, 1972).

RECOMMENDATIONS

1. Services should be delivered in the context of the ethnic group's own definition of its community.

2. Funding should be made available to settings that are part of the community's natural support systems.

3. Comprehensive support services must be available in order to adequately implement mental health service programs.

4. A flexible public housing policy should be instituted that would permit and encourage extended family households. 12. Training funds should be specifically designated to deal with the special needs of the minority American with developmental needs to train more bilingual/bicultural staff, and support the growth of consumer and self-help groups.

5. Viable alternatives to schools as they now exist must be established for minority youth in addition to a reorganization of educational systems that fail to achieve their socially designated missions, including governing structures involving administrators, parents, teachers, and children in decision-making.

6. Efforts should be addressed to the education of teachers in minority communities. Teachers need preparation to understand difficult behavior as lags in social and psychological development, capable of being modified. Minority children need to have successful experiences in school as a deterrent to dysfunctional social behavior.

7. Action oriented research by minority and majority researchers minority individuals and institutions must be supported to assess the strengths and survival strategies of minorities and to determine ways and means to foster the development and support of these assets for all.

8. Coping skills that have enabled minority children and adults to survive should be understood and this knowledge applied to programs of human development.

9. Consultation and educational programs, sponsored by community mental health agencies, should be established for minority community non-mental service providers and community organizations, in order to educate them as to their responsibility to minority communities.

10. There should be establishment and expansion of preventive programs of consultation and education which would impart bilingual/bicultural mental hygiene information to minority families, individuals, community organizations and service providers.

11. Mental health education programs (bicultural/bilingual) should receive high priority at local, state, and Federal level. Such programs should be planned and implemented by minority members to insure their relevance and sensitivity.

MINORITY PARTICIPATION, ACCOUNTABILITY, AND QUALITY ASSURANCE

If programs are to be developed which are culture-specific, address the needs of minorities in a holistic framework with linkages to other human services, and which build upon the autonomy and growth-enhancing and empowering abilities of natural support systems within local communities, then there must be a foundation of participation by minorities in the conception, planning, delivery and evaluation of those services. The literature would suggest that this participation has not taken place.

Several specifics may be cited. The National Health Planning and Resource Development Act and the Health Systems Agencies have an uneven, but inequitable representation of minorities. Even in large cities such as New York City with a sizable Asian American population, the representation of this particular minority on the policy making board is minimal and that of Hispanics little better. The representation of other minorities, including Black and Hispanics, in other cities remains grossly inadequate. Native Americans, as in so many other situations, are virtually completely ignored (Kalish & Moriwaki, 1973).

The HSAs have a vital role to play in determining the direction of the health care delivery system through whatever relationships are established with organizations currently responsible for planning mental health services. They and mental hygiene planners will play important roles in the future. It is essential that there be minority participation in solving the critical problems that face the field which have a considerable effect on minority health.

One of the critical problems that has to be attended to is the role of the

State psychiatric hospital in the future provision of community mental health services, as deinstitutionalization continues across the nation. Since, with the exception of Japanese-Americans, minorities are over-represented in State hospitals, consideration of the role of those institutions and of their lowly-paid staff (many of whom are often minorities) ought to involve minorities themselves along with others. Thus, there remains the necessity for greater involvement of minorities not only in such planning and policy setting bodies, but in local and state government boards, hospital advisory bodies, and CMHC governing boards, for example.

Indeed, to finance and deliver services requires not only policy set at national and state levels but its implementation at the county and local level. Here, as well, there is under-representation of minorities in decision-making. This situation prevails in many programs, even in areas of direct service. In spite of the fact that it became fashionable in the 60s, under the guise of New Careers Movement, to begin to train minorities for mental hygiene work, with the decrease in Federal funds and with the lack of emphasis on the New Careers Movement, persons hired to provide "a little local color" found themselves out of work. Although opportunities for professional minority members have also not kept pace with the development of mental hygiene programs, an equally great loss has been the abandonment of New Careers. Particularly, in mental health, alcoholism and drug abuse services, the roles that the paraprofessional New Careerist could play, in ways both culture- and community-relevant, could add to expediting services and enhancing therapy. It is not only that well-trained paraprofessionals may be helpful to minorities in service programs; they may play new roles within

the range of services to both minorities and majorities to allow the more efficient use of professional staff, in more consultative and administrative roles.

But this is dependent on skill, training and an appropriate deployment of both professional and paraprofessional staff according to client/patient need. For those programs which saw paraprofessionals as a "cheap" source of labor, the quality of service provided may well have been what was purchased. There should certainly not be an automatic assignment of paraprofessionals predominantly to minority patients; nor, on the other hand, should there be the assumption that a white, middle-class professional lacking a holistic approach and knowledge of the particular community, must assuredly be better by virtue of professional education.

For minorities, a serious concern remains over the shrinking Federal commitment to funding for professional as well as paraprofessional training. With the decrease in emphasis on funding for professionals in psychiatry and other professions, there still remain the problems that come from past and current racial discrimination. This has meant that for Indian Americans, Hispanic Americans from certain backgrounds and Afro-Americans, there are too few professionals. Even for Asians, among whom there are a larger number of certain health professionals, the majority of those who have been educated and trained are not Asian Americans from this country, but from others, nor are they serving Asian American communities (Berk & Hirata, 1973).

The needs of minorities to be involved as staff and as planners are complemented by their needs to be involved as citizens to whom programs

should be accountable and in advisory roles to those agencies monitoring the quality of care. Thus, it is essential in the organization of such bodies as the Professional Standards and Review Organizations, that minorities be not only among the physicians who comprise peer review groups but also among the providers and consumers who work and serve on PSRO specialty committees.

Considering the fact of the scarcity of professionals among certain minorities (for example, fewer than a dozen Native American psychiatrists in the country) the entree to quality assurance may have to come through the advisory groups to such bodies. Here again, for there to be accountability to minority communities, there must be citizen participation on each of these levels of planning, service delivery, and quality assurance (Christmas, 1977).

Discussion of quality assurance leads to the difficult problem of evaluation of services and the thorny issues of how the critical necessity for confidentiality can be maintained in a situation that requires accountablity to public agencies for information. This will be increasingly a problem as efforts are made to move from a non-system with marked fragmentation, resulting in the proverbial "falling between the cracks." The need for a mechanism to bring about effective referrals of individuals from one agency to another and the necessity to develop persons to assist people through the maze of agencies may be best met with a multi-service center. It might, on the other hand, require an information system, a single record, or a case manager. How can this be accomplished without breaching confidentiality? It is extremely difficult also when the multi-service approach is carried out through several agencies acting in a consortium, for example.

The issue of confidentiality becomes particularly important in minority communities when paraprofessional mental health workers, for example, are drawn from those communities and must work side by side with people who might, at least in smaller communities, be their neighbors. This must be addressed in a way that recognizes both the supportive role which friends and neighbors can play and the different role which volunteers and staff should play and distinguishes between the responsibilities and constraints that devolve upon each.

In regard to data sharing and to program evaluation, concerns that minorities hold about being "researched to death" are not groundless. Fear that information about their civil rights activities will be put into a master computer or their names go down on a government list are not reflective of 1984. Yet, data collection and research are necessary.

Little evaluation has taken place comparing the efficacy of various approaches for services to minorities in the mental health fields, indeed, as indicated, the literature is descriptive rather than analytical. As minorities come into their own, seeking an equitable share of a shrinking pie, they may be called to do what others have not had to do in the days of wine and roses -- to justify expenditures. If these studies are themselves to include reference to cultural variables, then the pool of culture-sensitive researchers has to be expanded (Sue, 1972). Here, too, even more than with service staff, minority personnel are lacking.

In addition, in order to begin to collect the kind of evaluation data that have not been collected in the past by mental health agencies, it is essential that some more objective outside bodies be able to conduct

evaluation both of the more traditional and also of the newer more innovative programs. This kind of program audit might involve not only professional staff of supervisory agencies, but, in the interest of accountablity, for example, the citizen from a neighborhood mental health council might participate in selected parts of site visits and program audits. The consumer view point is critical to quality assurance. If concern is raised as to why Chinese Americans, for example, under-utilize the few health services that are available to them, their views must be sought on the functioning of the service systems that do exist, both old and innovative. In some instances, this can be done through the participation of minorities as staff in mental hygiene administrative and supervisory organizations, in agency boards as, for example, the Patient Care/Client Service Committees of providers and consumers which will participate in New York City in such monitoring along with the City mental hygiene department.

What are the limits of confidentiality? What are the limits of agencies rights to supervise? What are the ways in which evaluation can be done without interfering with programs? These are questions that remain to be addressed.

RECOMMENDATIONS

1. Minority Americans (consumers and providers) must be included at all levels of the decision-making process in programs which serve minorities.
2. Minority Americans must be appointed to serve on all Federal, State, and local governmental boards, review committees, commissions, councils, and policy-making bodies, and especially where substantial numbers of minorities are affected.

3. Minority representation on HSA's must be mandated and such representation be reflective of the population over which the HSA has jurisdiction; this representation should be a condition of Federal funding.
4. PSROs should be mandated to include minorities on physician peer groups, specialty committees, and advisory bodies; this inclusion should be a condition of Federal funding.
5. Boards composed of minorities should be established to review and monitor hospitals, agencies, and other health facilities to insure complaince with DHEW regulations as they affect minorities.
6. Comprehensive investigations should be conducted to assess the quality and quantity of services provided to minority Americans by the Veterans Administration, the Social Security Administration, the Department of Labor, the former Office of Human Development, the Bureau of Indian Affairs, and other governmental bodies.
7. Investigation should be conducted of services being provided to Indian families on Indian reservations and in Indian communities
8. ADAMHA should allocate a portion of its research budgets, intramural and extramural, for (a) the development of normative data on minorities, (b) the development by minority researchers of culturally relevant assessment instruments, (c) development of standards of service delivery,(d) review of geographical/political/social locations of CMHC's and the effects on service of such sites, (e) action-oriented research, (f) evaluation of service approaches, and (g) effects of years of prejudice and racism on both minority and majority.

9. There needs to be strong, vigorous and immediate action on the part of the Federal government to insure quality, community-based, holistic coordination, integrated helping services for minority Americans; these services must be based on local need, local planning and local decision-making and include health, social service, employment, educational, and economic programs.
10. The Federal government should take a more active role in providing incentives for training minorities as professionals and para-professionals. Such training programs should take into account the barriers institutionalized racism imposes on effective treatment. Minority professionals in mental health are critically needed not only to provide direct services, especially rehabilitation, but as mental health administrators and managers dealing with policy, fiscal, informational and programmatic issues.

FINANCING

Basic to the service characteristics which have been discussed are recommendations for a sound fiscal base. The elements of appropriate services for minorities cannot exist without the fiscal base that ensures that funds are available for innovative linkages with community organizations, new types of personnel, traditional folk medicine as well as Western medicine, and public education of communities in regard to individual and institutional responsibilities.

If the parameters of mental health, drug abuse and alcoholism services are to be broadened to include the social elements which are a part of a holistic orientation, then there must be funding that draws not only from the health care system, but appropriately from other funding sources, such as social services, into a single stream.

Consistent with this is the need for funding to come to the local level where services should be integrated, to that level with the greatest accountability and responsiveness. There is, further, the necessity for less reliance on categorical funding (not to eliminate it, for it may be the only way of reaching certain target groups who are overlooked) but to lengthen cycles for funding so that innovative programs do not have to endure the annual stress of proposal writing and project refunding, efforts which divert energies from service (Christmas, 1977 b)

The financial base that may come with National Health Insurance is another critical area which may provide a key as to whether innovative services are to be a thing of the past. The recent tendency to define services more narrowly along medical lines may be an appropriate prelude to ensure that certain disciplines are included under National Health Insurance, but is not necessarily the way to ensure the provision of the most appropriate services.

Further, Federal leadership through legislation and regulations which take into account the needs of minorities can be the catalyst for significant reform.

RECOMMENDATIONS

1. The Federal government should consider establishing minimum standards for care and treatment for all states receiving Federal funding. This may be difficult to insure if Federal authority is limited to the boundaries of a particular funding program. However, the Federal government should give consideration to imposing its presence more specifically in terms of care and treatment received by the mentally disabled who are also minorities.
2. DHEW should ensure adequate funding of mental health delivery system serving minority communities. In addition, much needed consultation and education services, and the research and development programs which are not reimbursable as direct treatment services must be maintained.

3. Adequate and stable funding should be provided to continue the operation of CMHCs or networks of community mental health services. Implicit in this recommendation is the need to stipulate a firm and stable shared commitment on the part of Federal and State governments to the continued funding of mental health services, and to foster flexibility in design and sponsorship.
4. Consideration should be given to amending P.L. 94-63, allowing extension of funding period for more than eight years, and/or the increased use of distress grants.
5. (a) Where CMHCs serve large Medicaid/care populations, Federal initiatives should ensure reasonable coverage of ambulatory psychiatric services under Medicaid/care.
   (b) Where CMHCs serve a working poor population not eligible for coverage, mechanisms for long-term funding must be established.
6. The Federal government should act through funding restrictions and guidelines within Federal authority to prohibit discriminatory state and local practices with respect to providers and recipients of service.
7. A related problem is the undue influence which is often exerted by the provider arm of a state government. Federal standards should consider mandating a separation within a state between the provider arm, if one has to exist, and that state agency which engages in standard setting, the awarding of agency contracts and revenue distributions. An independent oversight

agency might be mandated to insure effectively separate functioning.

8. If mental hygiene funds are allocated as part of larger social services funding schemes, such as Title XX, it is critical that careful definitions of care and treatment programs be included by the Federal government and minimum percentages of Federal funds be required for such programs.
9. Mechanisms be developed at the Federal level to secure strict enforcement of, and compliance to, existing legislation pertaining to all mental health facilities and participation by minorities in the implementation of such procedures.
10. Each community mental health facility must be held accountable to serve all ethnic groups within its area of coverage.
11. P.L. 94-63 Title III "Community Mental Health Centers" should be amended to identify minority populations as target populations for this legislation.
12. P.L. 94-63 - Title III "Community Mental Health Centers" should be amended to ensure the establishment of a sufficient number of mental health delivery mechanisms to ensure that minorities have true access to quality mental health services.
13. Training and licensure requirements must be re-examined and modified to take into account shortage of bilingual and bi-cultural licensed personnel to certain minority groups.
14. There should be enacted a bill to establish a Division for Minority Group Health Programs to include Asian and Pacific Americans, Blacks, Hispanics, and Native Americans.

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